Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 10/24/11
Amount 2160.00

#12425

I. IDENTIFICATION

Name: Regency Care of Mount Sterling LLC dba Windsor Care Center

Address: 125 Sterling Way

City/County/Zip: Mount Sterling / Montgomery / 40353

Telephone number: 859-498-3343 administrator@windsorcare.com

Administrator: Rebecca L. Cooley

Date facility operation began at current address: 10-01-1976

Date facility began operation under current owner: 04-01-2010

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	144	144
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit X	Individual
County	Nonprofit	Partnership
City		Corporation
Private X		LLC X

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

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OCT 28 2011
OFFICE OF INSPECTOR GENERAL

(OVER)

JL

If facility owned or leased by a corporation, complete the following:

Name of corporation Regency Care Holding, LLC

Address of corporation P.O. Box 1667, 1978 Eighth Ave NW, Hickory, NC 28603

President or Chairman Steven D. Womack

Vice President

Secretary

Treasurer

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company **WW Health Care Consultants, LLC**
	P.O. Box 1667
	Hickory, NC 28603

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative	Title	Date
	Administrator	10/27/11

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)